

# COOLAROO CLINIC

## COMPLAINTS FORM

The information **MUST** be completed to investigate your complaint.

### COMPLAINANT INFORMATION

Name	Address	Contact Details

### WHAT IS REASON FOR YOUR COMPLAINT? TICK APPROPRIATE

<input type="checkbox"/> Quality of Care	<input type="checkbox"/> Abuse	<input type="checkbox"/> Patient abandonment/neglect	<input type="checkbox"/> Other, please explain....
<input type="checkbox"/> Misdiagnosis	<input type="checkbox"/> Sexual contact	<input type="checkbox"/> Impaired provider	
<input type="checkbox"/> Customer Service	<input type="checkbox"/> Misfiled prescription	<input type="checkbox"/> Failure to release patient records	
<input type="checkbox"/> Work Cover	<input type="checkbox"/> Inappropriate prescribing	<input type="checkbox"/> False advertising	
<input type="checkbox"/> Billing	<input type="checkbox"/> Excessive test/treatment		

### DETAILS OF THE COMPLAINT

**Provide a complete description of the complaint. Include facts, details, dates, locations, who, whom, when & where**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required to file complaint)

*Thank you for your feedback. It is our policy to respond to your complaint/feedback within 7 business days.*